

**MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM**

For Version 005010 HIPAA Transaction Set

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

- | | |
|---|--|
| 1. This is a | Select Media if New Application: |
| <input type="checkbox"/> New Application | <input type="checkbox"/> Electronic Transfer & Paper Voucher |
| <input type="checkbox"/> Change of Submitter Agent | <input type="checkbox"/> Paper Voucher Only |
| <input type="checkbox"/> Submitter Identification Form Update | |

2. Provider Information

a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	

3. Electronic Submitter Information

a) Submitter Name:	
b) Submitter Address:	
c) Submitter ID(ISA Qualifier and ISA ID):	

4. EDI Information

Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	005010X279A1
	276/277 Claim Status & Response	005010X212
	837 Health Care Claim Institutional /277CA Claim Acknowledgment	005010X223A2 /005010X214X
	837 Health Care Claim Professional /277CA Claim Acknowledgment	005010X222A1 /005010X214X
	837 Health Care Claim Dental /277CA Claim Acknowledgment	005010X224A2 /005010X214X
	820 Premium Payment	005010X218
	835 Health Care Claim Payment/Advice 835 GS Receiver ID <u>(Required, if Checked)</u> Receiver EDI Information (Required if different from above listed Submitter ID or if you are a Pharmacy Provider or Business Associate requesting an 835): Receiver Name: Receiver Address: ISA Qualifier and ISA ID:	005010X221A1

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The provider, _____ hereby authorizes

PROVIDER NAME

_____, hereafter

SUBMITTER AGENT

referred to as Submitter Agent, to transmit our Medicaid claims to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the Submitter Agent the return computer file electronic vouchers of all claims data processed, indicating paid, rejected, denied and pended claims (with error codes). The Submitter Agent agrees to protect the confidentiality of this data as required by law.

Signature of Provider

Signature of Submitter Agent

Print Name of Signature

Print Name of Signature

Telephone Number

Date

Telephone Number

Date

Note: This form requires completion of all requested information and original signatures to be processed.

MAIL TO:

**SYSTEM LIAISON SERVICES
201 W. PRESTON ST., RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK**

For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____